

June 1, 2004

MDR Tracking #: M2-04-1300-01

IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ___ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Medical Doctor board certified and specialized in Physical Medicine and Rehabilitation. The reviewer is on the TWCC Approved Doctor List (ADL). The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

___ sustained a closed head injury while working as an OR nurse on ___. She subsequently developed headaches, neck pain and low back pain. ___, a neurologist, and her present treating doctor saw her initially on 08/01/02. ___ began treatment with analgesics, muscle relaxants and various psychotropic medications which apparently have been continued to the present time. The patient was also referred to a chiropractor for treatment of her neck and back pain. The medical records indicate an initial individual psychotherapy session on 10/16/02, followed by regular sessions through 06/25/03. She underwent at least ten sessions of biofeedback training between 10/15/02 and 04/09/03. Between 06/25/03 and 09/23/03 the patient had several hypnotherapy sessions. She has been followed regularly by a behavioral neurologist. After all this time and treatment she is still unable to work, as she is disabled by a myriad of somatic and psychological symptoms.

REQUESTED SERVICE

A chronic pain management program consisting of 30 sessions (six hours each, five days a week) including biofeedback, individual and group therapy, hypnosis, physical rehab and educational groups is requested for this patient.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

This patient does not appear to be functioning at any better level low compared to a year and a half ago in spite of the above interventions and continued attention of medical providers. A chronic pain management program of daily therapeutic exercise, biofeedback, individual and group therapy and hypnosis is unlikely to be of significant benefit for this patient who has already

had extensive amounts of physical therapy individual psychotherapy and counseling biofeedback and hypnotherapy. The reviewer finds that this patient has no reasonable probability of improving any further on more of the same delivered in the "pain camp" style.

The proposed chronic pain management program is neither appropriate nor medically necessary for the treatment of this patient's injury.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy.

As an officer of ___, Inc, dba ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

YOUR RIGHT TO REQUEST A HEARING

Either party to medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision, a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) calendar days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

If disputing other prospective medical necessity (preauthorization) decisions, a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) calendar days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings / Appeals Clerk
P.O. Box 17787
Austin, Texas 78744
Fax: 512-804-4011

The party appealing this decision shall deliver a copy of its written request for a hearing to other party involved in this dispute.

I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 24th day of May 2004.